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REMARKS OF HENRY A. WAXMAN, CHAIRMAN
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ON
MEDICAID IN THE 1990'S
BEFORE THE
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Good morning. Today is the last day of the first month of the last decade in the 20th century. Every writer is putting together lists of "Where Are We and Where Are We Going?"

As I think about these questions, I remember that Hubert Humphrey said,

"...the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life--the sick, the needy, and the handicapped.

These are precisely the populations that the Medicaid program serves -- children, elderly, and disabled. Is government meeting its moral test? Let's look at what progress was made during the 80's, the program as it stands today, and where it should be going over the next 10 years.

Advances of Medicaid in the Eighties

Let's start by looking backward. The 80's saw four major advances in Medicaid.

Endurance

First, it endured. The program was able to continue financing basic health care for the poor without serious interruption. It remained an entitlement in the face of vigorous Reagan Administration efforts to "cap" it. Federal Medicaid spending has grown by 208 percent over the past decade, rising from $14.4 billion in 1980 to an estimated $38 billion this year.

The program also survived efforts to destabilize it by imposing automatic, across-the-board cuts under Gramm-Rudman law. Because Medicaid and other means-tested entitlement programs are exempt from sequestration, they are not affected by the 1.4 percent reduction now being applied to all non-defense programs in the most recent Budget Reconciliation bill. I should note that if Medicaid were subject to such a reduction for this year, Federal Medicaid payments to the States this year would drop by more than half a billion dollars.

I doubt that the States would be able to make up the shortfall.

Infant Mortality

The second advance was that, by the mid-80's, people had come to recognize Medicaid as an essential part of any effort to reduce this nation's deplorable infant mortality rate. This recognition led to the uncoupling of welfare and Medicaid eligibility for pregnant women and infants. As of April 1 of this year, all States will be required to extend Medicaid coverage to all pregnant women and children up to age 6 with incomes below 133 percent of the Federal poverty level, whether or not they are receiving cash welfare. This will extend Medicaid coverage to an estimated 88,000 pregnant women and 747,000 infants and young children next year.

Community Care

Third, the program took the first steps toward reducing its

institutional bias for the elderly and disabled populations requiring long-term care. Nearly 45 percent of the Medicaid dollar, or $17 billion in Federal funds, is spent on care provided by nursing facilities or by intermediate care facilities for the mentally retarded. This figure does not include spending for long-term care patients backed up in hospitals awaiting nursing home or community placement. A major reason was that the program paid only for nursing home or ICF/MR care, and not for home or community-based services.

In 1981, the Congress enacted a waiver authority which allowed the States to use Federal Medicaid funds to provide home and community-based services to elderly or disabled individuals at risk of nursing home or hospital care. (There was a catch -- States had to show that their waivers would be budget neutral. This has limited the availability of the benefit.) Nonetheless, the waivers have been used by most of the States, and have reached a large number of people: over 79,000 elderly and 27,000 disabled. Of course, spending on nursing home care and ICF/MR services still far outstrips spending for home and community-based services.

Reimbursement Improvements.

The fourth major advance during the 1980's was in Medicaid reimbursement policy. Don't groan; things could have been much worse.

At least the program began to acknowledge the plight of hospitals serving disproportionate numbers of Medicaid and other low-income patients. After several years of delay by the Reagan Administration and many of the States, the Congress enacted a fairly specific mandate for payment adjustments to disproportionate share hospitals. While implementation is far from uniform, in a number of States these disproportionate share payments have helped some facilities to continue to operate as providers of last resort for their communities.

As bad as Medicaid reimbursements may seem to you, things are arguably worse for physicians in many States. A 1986 study found that, for brief follow-up visits to specialists, State Medicaid payments averaged 67 percent of Medicare levels, with some States as low as 33 percent of Medicare. In last year's reconciliation bill, we began the process of reforming physician payment under Medicaid by requiring States to set payments levels at a point where sufficient numbers of physicians would actually participate in program. We also asked the Physician Payment Review Commission to review the situation and come back to us with further recommendations.

Medicaid in the Nineties

So, as we enter the 1990's, where does the program stand? It reaches over 25 million poor people.

About half of these are children. Over one fifth are mothers and other caretaker relatives. Nearly one sixth are elderly. The remaining sixth are disabled.

Medicaid plays a critical role for each of its populations.

For poor and working poor families, Medicaid remains far and away the most important health care program, even though it still leaves millions of them uncovered.

For the elderly, Medicaid remains far and away the largest public program for nursing home care, even though it requires the elderly to impoverish themselves before qualifying for benefits. Roughly 40 percent of all nursing home revenues come from Medicaid.

For individuals with mental retardation, Medicaid is the single largest source of funding for institutional services. In 1988, Federal Medicaid payments accounted for 46 percent of all spending for

institutional care.

For people with AIDS, Medicaid is the last shred of the safety net, paying for the care of 40 percent of Americans who are living with and dying of AIDS.

What this means is that, whether the issue is coverage for the uninsured or protection against the costs of long-term care, Medicaid -- and the populations it serves -- are central to the debate.

The Pepper Commission

As you know, when we enacted the Medicare Catastrophic legislation in 1988, we established a Bipartisan Commission on Comprehensive Health Care. The Commission is a tribute to Senator Pepper, who was astute enough to see that real issues were not protection against high hospital and physician costs, but health care for the uninsured and long-term care.

The mission of the Pepper Commission is to develop recommendations to the Congress and the President to solve the uninsured and long-term care crises in this country. The recommendations are due March 1.

No problem.

The Commission is composed of 6 Members of the Senate, 6 Members of the House, Democrats and Republicans, and 3 Presidential appointees. Their views run the spectrum from advocates of comprehensive national health insurance to advocates of a system of tax-driven market incentives. As one of the Members, I can tell you that Chairman Rockefeller is absolutely committed to developing a workable and politically viable set of recommendations that have a chance of enactment. I think he will succeed.

What Should Be Done?

I don't know at this point precisely where the Commission will come out. But I'd like to share with you some of my thoughts on how we create a health care system that can improve the health status of our people without bankrupting us all.

Begin with Employment-based Coverage

I would begin by building on the existing job-based system of health care coverage. If we were starting from scratch, I might not want to tie health care coverage to employment. But we're not starting from scratch. Most of those who have insurance coverage in this country have it through their workplace. In my judgment, the only realistic course is to start where we are and improve upon it.

My improvements would be along the following lines. First, I'd require all employers, large and small, either to offer their employees and dependents a basic set of benefits, or to contribute a percentage of their payroll toward a public plan. Thus, health care coverage would become a cost of business for all employers; no employer could undercut the competition by denying coverage to its workers and their families.

As the small businesses will be quick to point out, this approach waddles and quacks like a tax. But we are not going to fix our health care system unless everyone pulls his oar. And that includes employers. Without employer participation, the only alternative is a massive public plan, the costs of which would be prohibitive.

Now it would be completely unreasonable to require employers to offer coverage without making some major changes in the marketplace in which they have to purchase that coverage.

-- Employers need access to basic coverage at an affordable price.

This means requiring insurers to offer basic policies without medical underwriting and without experience rating.

-- They need some way to limit provider price increases. This means giving the purchasers of health care the leverage to negotiate effectively with hospitals and physicians.

-- They need protection against mandates of additional benefits imposed by States. This means preempting State minimum benefits laws with a uniform Federal basic benefit requirement.

And The Rest Not Employment-Based

There are a fair number of people who would not be reached by the employer-based system -- part-time workers, the unemployed, and the poor. For these people, and for the workers of those employers who elect to pay the contribution rather than offer coverage, I would establish a new public plan.

Specifically, I would replace the Medicaid program with a Federally financed, Federally administered entitlement program offering a uniform basic benefit package throughout the country. This new program would not be only for the poor. It would be completely divorced from the welfare system, and private employers would be able to buy their employees into it if they chose to do so. It would pay providers far more reasonable compensation for their services than many State programs now do.

The current Medicare program would be retained for the elderly and the disabled.

Any program we enact will have to include cost controls. I know that you as an industry have some problems with this, but I have to tell you that our society has a serious problem with the high rates of inflation in the health care sector. What we've got now is a game in

which each payor looks out for itself, and costs get shifted, not contained. That can't continue, particularly if we are going to put large amounts of additional Federal and employer dollars into the system to pay for the uninsured.

Even with effective cost controls, this new public program will cost money. Depending on how it was structured, and on how many employers opted not to offer their employees private coverage, the costs could range from about $28 billion to over $50 billion per year. That will require new taxes. I would favor using a progressive, broad-based income tax surcharge. We're all in this together.

Whatever the public costs of reform turn out to be, we have to decide what the relative responsibility of the Federal and State governments should be. Right now, both are heavily invested. This year, the Federal government will spend about $38 billion on Medicaid benefits, with States spending another $31 billion or so. On average, States spend an average of 9 percent of their budgets on Medicaid.

But there is a lot of variation. Some States spend as much as 14 percent, others as little as 3 percent. This has helped to produce incredible variation in eligibility, benefits, and reimbursement that has weakened the ability of the program to protect the health of beneficiaries.

As I mentioned earlier, my goal would be to Federalize the acute care portion of the Medicaid program, freeing up over $15 billion in State funds. I would require the States to reinvest these funds in a revamped Federal-State long-term care program covering both institutional and home care benefits.

The Time to Begin is Now

Whatever recommendations the Pepper Commission makes, it is

unlikely all of them will be enacted this year. The Congress and the American people will need some time to debate and discuss them. But I intend to begin that process this spring. The Administration is likely to urge that we wait until its two study groups complete their work. The Governors have already asked that we wait until they develop their own recommendations, late in 1991.

I do not intend to wait. The Pepper Commission report will lay out all the options and all the facts. We have to start making some decisions.

In the Meanwhile, Medicaid Must be Improved

While we move forward on broad reform, the Congress will continue the step-by-step process of considering and passing individual health initiatives.

Last year we made some progress in expanding the Medicaid program to more low-income pregnant women and young children. That will mean over 800,000 fewer people without health care coverage.

But that well over 30 million uninsured. Obviously, we need to do more.

My own goals for Medicaid in the 1990's are

o to increase the number of poor and working poor people that Medicaid covers;

o to improve Medicaid's reimbursement, so that beneficiaries will have access to more providers, and so that providers have the resources to deliver quality care;

o to reduce the institutional bias in Medicaid spending, so that

those in need of long-term care have the option of receiving needed services at home or in the community; and finally

o to increase Federal support for the acute care portion of the Medicaid program, hopefully as part of a broader set of health care reforms.

During the campaign, Candidate Bush promised to extend Medicaid coverage to all pregnant women and infants with incomes below 185 percent of the poverty level. He also promised to extend coverage to all poor children. I want to help him honor his commitments.

It makes no sense that only 15 States cover pregnant women and infants up to 185 percent of poverty, as the National Commission on Infant Mortality recommended.

It makes no sense that Medicaid does not cover all children under the poverty level, as the Office of Technology Assessment, the AHA, the Business Roundtable, and many others have recommended.

It makes no sense that Medicaid pays only for inpatient care for people with AIDS and not for preventive care for infected people to forestall their sickness and their need for hospitalization.

I know that these views are not terribly popular among the Nation's Governors. And I understand the fiscal and political pressures that these mandates create.

But I don't believe that the issue before this country is whether the States should have to spend more money on health care for the poor.

The issue is whether poor and working poor families need health care coverage. If responding to these needs really exceeds the

ability of States to finance the care, then that should translate into pressure for more Federal support, not a moratorium on progress.

Which brings us back to the mission of the Pepper Commission and Hubert Humphrey's moral test. I believe that reform of the health care system is inevitable during the 1990's, and that restructuring Medicaid along the lines I'vwe suggested will be an important part of that reform.

I hope that this organization will join me in that effort.